

FILED DEC 8 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. 38716
10096

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1002		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY 2120			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Saint Louis		c. LENGTH OF STAY (In this place) 2 Days		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Saint Louis		0	
d. FULL NAME OF HOSPITAL OR INSTITUTION Deaconess Hospital				d. STREET ADDRESS (If rural, give location) Good Samaritan Home 4500 Washington Blvd.			
3. NAME OF DECEASED (Type or Print)		a. (First) Doratheia		b. (Middle) W.		c. (Last) Kronsberg	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed		8. DATE OF BIRTH January 28th, 1873	
9. AGE (In years last birthday) 77		10. UNDER 1 YEAR Months 9		11. BIRTHPLACE (State or foreign country) St. Louis, Missouri		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Charles H. Schuermann		13b. MOTHER'S MAIDEN NAME Sophia Bartels		14. NAME OF HUSBAND OR WIFE Late Charles H. Kronsberg			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME W. H. Schuermann, Box 42, House Springs, Mo			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) acute intestinal obstruction ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Strangulated umbilical hernia DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 560.2					
22. I hereby certify that I attended the deceased from Nov. 23, 1950, to Nov. 26, 1950, that I last saw the deceased alive on Nov. 26, 1950, and that death occurred at 5:15 p.m., from the causes and on the date stated above.							
23a. SIGNATURE H. F. Bergman		23b. ADDRESS W.D. 0 3220 Washington		23c. DATE SIGNED 11/28/50			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 11/29/50		24c. NAME OF CEMETERY OR CREMATORY Zion Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis County, Missouri	
DATE REC'D BY LOCAL REG. NOV 28 1950		REGISTRAR'S SIGNATURE J. B. Passer		25. FUNERAL DIRECTOR'S SIGNATURE Calvin F. Feutz, 4828 Natural Bridge Blvd.			

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____

working under my personal supervision.

Student Embalmer No.

Signed _____

Ralph C. Linders

Signed _____

Student Embalmer

Licensed Embalmer No. *4225*

P. O. Address *St. Louis, Mo.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.